Authorization to Administer Medication – Ellicott D-22

Student: DOB:_____ Grade:

**Medical Provider Section
****

No known medication allergies:_____ Medication Allergies:_____

Known condition(s)/ diagnosis(es)_____

Medication:	Dose:	Route:	Time given at school:	Time given at home:

Medical Provider, over-the-counter medications listed below are available at the school.
Please indicate if the school staff may administer OTC medication to this child/student, the dose and frequency.

Oral Medication(s)

Acetaminophen 500mg tablet for c/o pain or to reduce fever <101 Yes____ No____ ____ tablet(s) every_____ hours
Acetaminophen 80mg chewable tablet for c/o pain or to reduce fever <101 Yes____ No____ ____ tablet(s) every_____ hours
Cough Drops (menthol/eucalyptus flavored) for c/o sore throat or cough Yes____ No____ ____ tablet(s) every_____ hours
Tums 750mg antacid tablets for c/o heartburn, indigestion, sour stomach Yes____ No tablet(s) every _____ hours

Topical Medication(s)/ application(s):

Triple antibiotic ointment applied to minor cuts/abrasions after cleaning with soap/water; cover with bandage Yes____ No____
Sunscreen, broad-spectrum/SPF 30 applied to unbroken skin that is exposed to sun Yes No

Medical Provider Signature_____ Date _____

Medical Provider print/stamp name, address, phone, fax:

****PARENT SECTION: REQUEST THAT SCHOOL ADMINISTER MEDICATION***

- I understand that my child attending Ellicott School District #22 does not self-carry or self-administer medication(s).
- I request and authorize that the medication(s) listed above be administered to my child by qualified school personnel in the manner specified as authorized by the medical provider.
- I understand that it is my responsibility to furnish the prescription medication to the school in its original pharmacy container with the current labeling of medication, dose, frequency, **any written instructions from the manufacturer or the student's physician regarding potential side effects,** and child's name.
- I understand that if my child requires prescribed emergency medication the medication is available to him/her when needed.
- I will notify the school immediately if the medication is to be changed or terminated or if we change physicians.
- It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian.
- In consideration of the acceptance of the request to perform this service by the school nurse, or other designee employed by the Pikes Peak School of Excellence, the undersigned parent or guardian, hereby agrees to release Ellicott School District #22 and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give permission for my child to take the above name prescription medication and/or OTC medication at school as prescribed.

Parent/Guardian Signature Date

My Child is enrolled in: Medicaid CHP+ Insurance No Insurance

I would like information about CHP+/Medicaid: Yes _____ No _____

Approved: March 5, 2015